Statement to the

Committee on Energy and Commerce
Subcommittee on Health
United States House of Representatives

"MEDICARE PHYSICIAN PAYMENT: 2007 AND BEYOND"

Presented by: Paul A. Martin, D.O.
President and CEO, Providence Medical Group—Dayton, Ohio
On Behalf of the American Osteopathic Association

September 28, 2006

Mr. Chairman, my name is Paul Martin. I am a family physician from Dayton, Ohio and currently serve as the Chief Executive Officer and President of the Providence Medical Group, a 41-member independent physician owned and governed multi-specialty physician group in the greater Dayton metropolitan area. I am honored to be here today on behalf of the American Osteopathic Association (AOA) and the nation's 59,000 osteopathic physicians practicing in all specialties and subspecialties of medicine.

The AOA and our members appreciate the continued efforts of you and the Committee to improve the nation's health care system. You are to be commended for your ongoing efforts to reform the Medicare physician payment formula and improve the quality of care provided by physicians. These are goals that we share.

I want to acknowledge and thank you, Chairman Barton, Ranking Member John Dingell, and Congressman Michael Burgess for proposing legislative solutions aimed at addressing this ongoing issue either in a short-term or long-term manner. The AOA supports these efforts.

MEDICARE PHYSICIAN PAYMENTS: 2007 AND BEYOND

Since its inception in 1965, a central tenet of the Medicare program has been the physician-patient relationship. Beneficiaries rely upon their physician for access to all other aspects of the Medicare program. Over the past decade, this relationship has been compromised by dramatic reductions in reimbursements, increased regulatory burdens, and escalating practice costs. Given that the number of Medicare beneficiaries is expected to double to 72 million by 2030, now is the time to establish a stable, predictable, and accurate physician payment formula. Such a formula must:

- Reflect the cost of providing care
- Implement appropriate quality improvement programs that improve the overall health of beneficiaries
- Reflect that a larger percentage of health care is being delivered in ambulatory settings versus hospital settings.

The AOA strongly supports the establishment of a new payment methodology that ensures every physician participating in the Medicare program receives an annual positive update that reflects increases in the costs of providing care to their patients. Moreover, the AOA is committed to ensuring that any new physician payment methodology reflects the quality of care provided and efforts made to improve the health outcomes of patients. As a result of this commitment, we support the establishment of standards that, once operational, will allow for the reporting and analysis of reliable quality data. Additionally, we support the establishment of a fair and equitable evaluation process that aims to improve the quality of care provided to beneficiaries.

The AOA continues to encourage Congress to take appropriate steps to ensure that all physicians participating in the Medicare program receive positive payment updates for 2007 and subsequent years. In its 2006 March Report to Congress, the Medicare Payment Advisory Commission (MedPAC) stated that payments for physicians in 2007 should be increased 2.8 percent. We strongly support this recommendation. Additionally, since 2001, MedPAC has recommended that the flawed sustainable growth rate (SGR) formula be replaced. Again, the AOA strongly supports MedPAC's recommendation.

It remains our opinion that the current Medicare physician payment formula, especially the sustainable growth rate methodology, is broken and should be replaced with a new formula that reimburses physicians in a more predictable and equitable manner. We recognize that comprehensive reform of the Medicare physician payment formula is both expensive and complicated. However, we believe that the long-term stability of Medicare, the future participation of physicians, and continued access to physician services for beneficiaries are dependent upon such actions.

The AOA believes that a future Medicare physician payment formula should provide annual positive updates that reflect increases in practice costs for all physicians participating in the program. Additionally, while we support the establishment and implementation of "pay-for-reporting" programs, we believe that these programs should be phased-in over a period of two to three years and that physicians choosing to participate in such programs receive bonus payments above the annual payment updates for their participation. Additionally, we do not believe that the current

Medicare payment methodology can support the implementation of a quality-reporting or pay-for-performance program.

Finally, we believe that a future Medicare physician payment formula should provide the framework for a more equitable evaluation and distribution of Medicare dollars. Under the current program, various components are isolated from each other, thus preventing a fair and thorough evaluation of overall spending. As Congress and the Centers for Medicare and Medicaid Services (CMS) establish new quality improvement programs, it is imperative that Medicare reflect fairly the increased role of physicians and outpatient services as cost savers, especially to the Part A Trust Fund. Quality improvement programs may increase spending in Part B, but very well could result in savings in Part A or even Part D. These savings should be credited to physicians. We encourage the Committee to pursue this as a means of stabilizing Medicare financially.

109th CONGRESS LEGISLATIVE PROPOSALS

Several bills aimed at providing both short-term and long-term solutions to the Medicare physician payment issue have been introduced in the 109th Congress. The AOA supports many of these bills and applauds the continued efforts of several Members of Congress and this Committee to find achievable solutions to this ongoing policy issue. Like most Members of Congress, the AOA believes that the year-to-year approach is not in the best interest of our members, beneficiaries, or the Medicare program. A long-term solution must be found. However, we also recognize that short-term interventions by Congress are essential to preserving physician participation in the program and beneficiary access to care while a permanent solution is debated.

Chairman Barton Discussion Draft

In general, we support the framework outlined in the "Barton Discussion Draft." Specifically, we support provisions of the draft that provide an immediate payment update for all physicians in 2007 while establishing a structure that provide annual positive updates for all physicians over multiple years, allow for a phased-in quality-reporting program, and provide positive payment incentives above the annual payment update for those physicians choosing to participate in the quality-improvement program. Additionally, we are supportive of including provisions that would allow physicians to balance bill beneficiaries, even if on a limited basis, for services provided.

Under the "Barton Discussion Draft," all physicians participating in the Medicare program would receive a 0.5 percent update in years 2007, 2008, and 2009. Physicians choosing to participate in both a quality reporting and resource utilization management program would be eligible for an additional 0.25 percent payment bonus.

We encourage the Committee to consider increasing the annual payment update to a level that more closely reflects annual increases in practice costs and to create a greater differential between the annual update and the bonus payments for participation in quality-improvement programs. While we appreciate the intent to establish predictability in physician payments over the next three years, we are concerned that the bill falls short of ensuring that physician reimbursements keep pace with annual increases in physician practice costs. Under the proposal, physician payments would increase 1.5 percent over the next three years, but practice costs likely will increase 7 percent to 8 percent.

The AOA agrees with the quality-reporting framework included in the draft bill. The AOA continues to advocate for a more deliberate and phased-in approach to the establishment of a pay-for-reporting and, ultimately, pay-for-performance program. We also agree that a "menu of options" is both advisable and appropriate. We applaud your intent to provide physicians with a variety of participation opportunities. By providing physicians options, the bill aims to maximize the number of physicians able and willing to participate in quality-improvement programs.

Additionally, the AOA encourages the inclusion of provisions that recognize participation in the AOA's web-based quality-reporting program, the Clinical Assessment Program (CAP), as meeting the requirement of participation in a quality-improvement program under the proposal. The CAP provides evidence-based measurement sets on eight clinical conditions including diabetes, coronary artery disease, hypertension, women's health screening, asthma, COPD, childhood immunizations, and low back pain. Data elements collected include both demographic and clinical information. The CAP is designed to collect data from multiple clinical sites and provide information regarding performance to participating physicians or group practices. This allows for the evaluation of care provided at a single practice site in comparison to other similar practice settings around the region, state, or nation.

The CAP is widely acknowledged by health care quality improvement experts and commercial insurers as a valuable tool that enhances quality in ambulatory care settings. The CAP produces valuable data on quality improvement. The AOA looks forward to working with the Committee to explore ways that the CAP may be incorporated into the Barton proposal.

Medicare Physician Payment Reform and Quality Improvement Act of 2006 (H.R. 5866)

The AOA thanks Congressman Burgess for introducing the "Medicare Physician Payment Reform and Quality Improvement Act of 2006" (H.R. 5866). The legislation is consistent with many AOA policies related to Medicare physician payment, quality reporting, and Medicare financing. For these reasons, the AOA is on record as a supporter of H.R. 5866.

H.R. 5866 eliminates the sustainable growth rate (SGR) and replaces it with a payment methodology that uses the Medicare Economic Index (MEI) for the purposes of the single conversion factor beginning in 2007. The provision requires that the single conversion factor shall be the percentage increase in the MEI minus 1 percentage point. This provision meets the AOA's policy objective of eliminating continued use of the SGR formula. The AOA does have concerns about including, in statute, a mandatory reduction in the MEI. We believe that all physicians should receive annual increases that reflect increases in costs, which we believe the MEI accomplishes. We recognize that Congressman Burgess and many Members of the Committee share this goal, but fiscal realities may make the adoption of a full MEI update impractical. The AOA looks forward to working with the Committee to ensure that the deduction of one percentage point in the MEI is eliminated at the earliest possible time following enactment.

The bill also establishes a voluntary quality reporting program for physicians, beginning in 2009. The AOA supports the phased-in approach used by H.R. 5866. We also are supportive of provisions that require quality measures used in the program to be developed by physician organizations and verified by a consensus organization.

Additionally, we strongly support provisions in H.R. 5866 that require the Secretary of Health and Human Services (HHS) to study the financial relationship of the independent components of the Medicare program and authorize balanced billing for physicians. It is important for Congress to consider changes in the Medicare funding formulas that allow for spending adjustments based upon

the financial health of the entire program. As Congress and CMS establish new quality improvement programs, it is imperative that Medicare reflects fairly the increased role of physicians and outpatient services as potential cost savers to the Part A Trust Fund. Quality improvement programs may increase spending in Part B, but very well could result in savings in Part A or even Part D. These savings should be credited to physicians. We appreciate Congressman Burgess for including this important study in his bill.

Patients' Access to Physician Services Act of 2006 (H.R. 5916)

The AOA thanks Ranking Member John Dingell for introducing the "Patients' Access to Physicians Act of 2006" (H.R. 5916). By ensuring positive payment updates for all physicians in 2007, the bill is consistent with AOA policies. For this reason, the AOA is on record as a supporter of H.R. 5916.

H.R. 5916 closely follows the recommendations put forth by MedPAC. H.R. 5916 would require that the annual update to the single conversion factor not be less than MEI plus 1 percentage point in 2007 and 2008. If enacted, our understanding is that H.R. 5916 would provide physicians with an approximate 2.8 percent update in both years.

The physician payment methodology in H.R. 5916 is supported strongly by the AOA. We recognize that the bill contains other provisions, which may or may not influence the cost of the legislation. The AOA does not have policies on these provisions.

A NEW PAYMENT METHODOLOGY FOR PHYSICIANS—THE SERVICE CATEGORY GROWTH RATE (SCGR)

The AOA worked with the American College of Surgeons (ACS) to develop a payment methodology that would provide positive annual updates to physicians based upon increases in practice costs, while being conducive to quality improvement and pay-for-performance programs.

The AOA and ACS propose replacing the universal volume target of the current sustainable growth rate (SGR) with a new system, known as the service category growth rate (SCGR), that recognizes the unique nature of different physician services by setting targets for six distinct service categories of physician services. The service categories, which are based on the Berenson-Eggers type-of-

service definitions already used by CMS, are: evaluation and management (E&M) services; major procedures (includes those with 10 or 90 day global service periods) and related anesthesia services; minor procedures and all other services, including anesthesia services not paid under physician fee schedule; imaging services and diagnostic tests; diagnostic laboratory tests; and physician-administered Part B drugs, biologicals, and radiopharmaceuticals.

The SCGR target would be based on the current SGR factors (trends in physician spending, beneficiary enrollment, law and regulations), except that the gross domestic product (GDP) would be eliminated from the formula and be replaced with a statutorily set percentage point growth allowance for each service category. To accommodate already anticipated growth in chronic and preventive services, we estimate that E&M services would require a growth allowance about twice as large as the other service categories (between 4-5 percent for E&M as opposed to 2-3 percent for other services). Like the SGR, spending calculations under the SCGR system would be cumulative. However, the Secretary would be allowed to make adjustments to the targets as needed to reflect the impact of major technological changes.

Like the current SGR system, the annual update for a service category would be the Medicare medical economic index (MEI) plus the adjustment factor. But, in no case could the final update vary from the MEI by more or less than 3 percentage points; nor could the update in any year be less than zero. The formula allows for up to one percentage point of the conversion factor for any service category to be set aside for pay-for-performance incentive payments.

Like the SGR, the SCGR would retain a mechanism for restraining growth in spending for physician services. It recognizes the wide range of services that physicians provide to their patients. Unlike the current universal target in the SGR, which penalizes those services with low volume growth at the expense of high volume growth services, the SCGR would provide greater accountability within the Medicare physician payment system by basing reimbursement calculations on targets that are based on a comparison of like services and providing a mechanism to examine those services with high rates of growth. Reimbursement for low growth services would not be forced to subsidize these higher growth services. By recognizing the unique nature of different physician services, the SCGR would enable Medicare to more easily study the volume growth in different physician services and determine whether or not volume growth is appropriate.

Additionally, the AOA believes the SCGR would provide a sound framework for starting a basic value-based purchasing system. Given the diversity of physician services provided to patients, it is difficult to find a set of common performance measures applicable to all physicians. However, development of common performance measures is much easier when comparing similar services.

CLINICAL ASSESSMENT PROGRAM (CAP)—A MODEL FOR QUALITY-REPORTING

In 2000, building on the hypothesis that some barriers to transforming evidence into practice may begin during physician post-graduate training and that measurement is key to identifying opportunities for incorporation of evidence-based measures into practice, the AOA launched the web-based Clinical Assessment Program (CAP). The goal of the CAP is to improve patient outcomes by providing valid and reliable assessments of current clinical practices and process sharing of best practices in care delivery.

The CAP provides evidence-based measurement sets on eight clinical conditions including diabetes, coronary artery disease, hypertension, women's health screening, asthma, COPD, childhood immunizations, and low back pain. Data elements collected by the residency training programs include both demographic and clinical information. CAP has been widely acknowledged as a tool to improve quality in ambulatory care and is beginning to provide data on quality improvement. For example, the percent of diabetics having foot exams performed routinely increased 24% in programs re-measuring as of June 2006. Likewise, in outcome of care measures, the LDL cholesterol levels and diabetic HgbA1c have decreased.

The CAP collects data from multiple clinical programs and provides information regarding performance back to participating residency programs. This allows for evaluation of care provided at a single practice site in comparison to other similar practice settings around the region, state, or nation.

The CAP initially measured the quality of care in clinical practice in osteopathic residency programs. In December 2005, the CAP became available for physician offices offering initial measurement sets

on diabetes, coronary artery disease, and women's health screening. The "CAP for Physicians" measures current clinical practices in the physician office and compares the physician's outcome measures to their peers and national measures. The AOA looks forward to working with Congress and CMS to explore ways that the CAP may be incorporated into broader quality reporting and quality measurement systems.

QUALITY IMPROVEMENT AND PAY FOR PERFORMANCE

Today's health care consumers—including Medicare beneficiaries—demand the highest quality of care per health care dollar spent. The AOA recognizes that quality improvement in the Medicare program is an important and worthy objective. For over 130 years osteopathic physicians have strived to provide the highest quality care to their millions of patients. Through those years, standards of care and medical practice evolved and changed. Physicians changed their practice patterns to reflect new information, new data, and new technologies.

As a physician organization, we are committed to ensuring that all patients receive the appropriate health care based upon their medical condition and the latest research information and technology. The AOA recognized early on the need for quality improvement and the national trend toward quality improvement programs. In response, we took steps to ensure that our members were prepared for these new programs.

Measure Development, Verification, and Adoption

The AOA believes that physicians, on a specialty-by-specialty basis, should develop all quality measures that will be used in quality improvement programs—both public and private. The AOA is an active participant in the Physician Consortium for Performance Improvement (Physician Consortium). The Physician Consortium develops measures in a cross-specialty manner that allows for input by all relevant physician specialties, CMS, private insurers, and consumer groups throughout the process. Public and private payers also have an opportunity for input as part of the process. Quality measures developed are subjected to public comment before being sent to the full Physician Consortium for final approval.

The Physician Consortium, in our opinion, should be recognized as the entity charged with the development of physician quality measures under any new program. Additionally, we believe safeguards should be put in place that protect against the undue influence of public agencies or private interest groups who could gain by the adoption of certain standards. However, the AOA does support the ability of appropriate outside groups with acknowledged expertise to already endorse developed standards.

We do not believe that CMS or other Federal agencies should be allowed to implement quality measures unless they were developed by physicians, vetted by the Physicians Consortium, and verified by an independent consensus body. This process, while time consuming, is essential to ensure that the measures are evidence-based and promote positive outcomes for patients. We support the interim adoption of some quality measures, so long as they originate within a physician organization.

Quality-Reporting Principles

As the national debate on the issues of quality reporting and pay-for-performance began, the AOA established a set of principles to guide our efforts on these important issues. These principles represent "achievable goals" that assist in the development of quality improvement systems while recognizing and rewarding the skill and cost benefits of physician services.

To support this goal, the AOA adopted the following five principles:

1. Quality-reporting and/or pay-for-performance systems whose primary goal is to improve the health care and health outcomes of the Medicare population must be established. Such programs should not be budget neutral. Appropriate additional resources should support implementation and reward physicians who participate in the programs and demonstrate improvements. The AOA recommends that additional funding be made available through the establishment of bonus-payments.

2. To the extent possible, participation in quality reporting and pay-for-performance programs should be voluntary and phased-in. The AOA acknowledges that failure to participate may

decrease eligibility for bonus or incentive-based reimbursements, but feels strongly that physicians must be afforded the opportunity to not participate.

3. Physicians are central to the establishment and development of quality standards. A single set of standards applicable to all physicians is not advisable. Instead, standards should be developed on a specialty-by-specialty basis, applying the appropriate risk adjustments and taking into account patient compliance. Additionally, quality standards should not be established or unnecessarily influenced by public agencies or private special interest groups who could gain by the adoption of certain standards. However, the AOA does support the ability of appropriate outside groups with acknowledged expertise to endorse developed standards that may be used.

4. The exclusive use of claims-based data in quality evaluation is not recommended. Instead, the AOA supports the direct aggregation of clinical data by physicians. Physicians or their designated entity would report this data to the Centers for Medicare and Medicaid Services (CMS) or other payers.

5. Programs must be established that allow physicians to be compensated for providing chronic care management services. Furthermore, the AOA does not support the ability of outside vendors, independent of physicians, to provide such services.

<u>Resource Utilization and Physician Profiling Principles</u>

Over the past few years, Congress, MedPAC and other health policy bodies have placed greater emphasis on controlling the use of "resources" by physicians and other health care providers. The AOA supports, in concept, a systemic evaluation of resource use that measures overuse, misuse, and under use of services within the Medicare program.

Additionally, we do not oppose programs that confidentially share with physicians their resource use as compared to other physicians in similar practice settings. However, any effort to evaluate resource use in the Medicare program must not be motivated solely by financial objectives. Instead, the AOA believes that physician utilization programs must be aimed at improving the quality of care provided to our patients. In measuring the performance of physicians, the singular use of utilization

measures without evaluation of clinical process and outcomes can lead to adverse impact on care delivery. Tracking methods to determine the unintended consequences of reduced utilization on patient safety should be incorporated in any utilization reports developed.

If the intent of the program is to improve the quality of care, then the validity, reliability, sensitivity, and specificity of information intended for private or public reporting must be very high. Comparative utilization information cannot be attained through administrative or claims-based data alone without adequate granulation for risk adjustment.

To support the establishment of quality improvement programs that stand to benefit the quality of care provided to patients, the AOA adopted the following ten principles that guide our policy on comparative utilization or physician profiling programs:

1. Comparative utilization or physician profiling should be used only to show conformity with evidence-based guidelines.

2. Comparative utilization or physician profiling data should be disclosed only to the physician involved. If comparative utilization or physician profiling data is made public, assurances must be in place that promise rigorous evaluation of the measures to be used and that only measures deemed sensitive and specific to the care being delivered are used.

3. Physicians should be compared to other physicians with similar practice-mix in the same geographical area. Special consideration must be given to osteopathic physicians whose practices mainly focus on the delivery of osteopathic manipulative treatment (OMT). These physicians should be compared with other osteopathic physicians that provide osteopathic manipulative treatment.

4. Utilization measures within the reports should be clearly defined and developed with broad input to avoid adverse consequences. Where possible, utilization measures should be evidenced-based and thoroughly examined by the relevant physician specialty or professional societies.

5. Efforts to encourage efficient use of resources should not interfere with the delivery of appropriate, evidence-based, patient-centered health care. Furthermore, the program should not impact adversely the physician-patient relationship or unduly intrude upon a physician's medical judgment. Additionally, consideration must be given to the potential overuse of resources as a result of the litigious nature of the health care delivery system.

6. Practicing physicians must be involved in the development of utilization measures and the reporting process. Clear channels of input and feedback for physicians must be established throughout the process regarding the impact and potential flaws within the utilization measures and program.

7. All methodologies, including those used to determine case identification and measure definitions, should be transparent and readily available to physicians.

8. Use of appropriate case selection and exclusion criteria for process measures and appropriate risk adjustment for patient case-mix and inclusion of adjustment for patient compliance/wishes in outcome measures, need to be included in any physician specific reports. To ensure statistically significant inferences, only physicians with an appropriate volume of cases should be evaluated. These factors influence clinical or financial outcomes.

9. The utilization measure constructs should be evaluated on a timely basis to reflect validity, reliability and impact on patient care. In addition, all measures should be reviewed in light of evolving evidence to maintain the clinical relevance of all measures.

10. Osteopathic physicians must be represented on any committee, commission, or advisory panel, duly charged with developing measures or standards to be used in this program.

As quality-reporting, pay-for-performance, and resource utilization programs become more prevalent, fundamental issues must be addressed. Some of our top concerns are:

- Quality and pay-for-performance programs must be developed and implemented in a manner that aims to improve the quality of care provided by all physicians. New formulas

must provide financial incentives to those who meet standards and/or demonstrate improvements in the quality of care provided. The system should not punish some physicians to reward others.

- The use of claims data as the sole basis for performance measurement is a concern. Claims data does not reflect severity of illness, practice-mix, and patient non-compliance. These issues and others are important factors that must be considered. Sole reliance on claims data may not indicate accurately the quality of services being provided. We believe that clinical data is a much more accurate indicator of quality care.

- The financial and regulatory burden quality and pay-for-performance programs will have upon physician practices, especially those in rural communities, must be minimized. Physicians, and medicine in general, have one of the highest paperwork burdens anywhere. We want to ensure that new programs do not add to physicians' already excessive regulatory burden.

- Quality and pay-for-performance programs should have some degree of flexibility. The practice of medicine continuously evolves. Today's physicians have knowledge, resources, and technology that didn't exist a decade ago. This rapid discovery of new medical knowledge and technology will transform the "standards of care" over time. It is imperative that the quality reporting and pay-for-performance system have the infrastructure to be modified as advances are made.

ANALYSIS OF CURRENT MEDICARE PHYSICIAN PAYMENT POLICIES

In 2002, physician payments were cut by 5.4 percent. Thanks to the leadership of this Committee, Congress averted payment cuts in 2003, 2004, 2005, and 2006 replacing projected cuts of approximately 5 percent per year with increases of 1.6 percent in 2003, 1.5 percent in 2004 and 2005, and a freeze at 2005 levels for 2006.

The AOA and our members appreciate the actions taken over the past four years to avert additional cuts. However, even with these increases, physician payments have fallen further behind medical

practice costs. Practice costs increases from 2002 through 2006 were approximately two times the amount of payment increases.

According to CMS, physicians are projected to experience a reimbursement cut of 5.1 percent in 2007 with additional cuts predicted in years 2008 through 2015. Without Congressional intervention, physicians face cuts of greater than 37 percent in their Medicare reimbursements over the next eight years. During this same period, physician practice costs will continue to increase. If the 2007 cut is realized, Medicare physician payment rates will fall 20 percent below the government's conservative measure of inflation in medical practice costs over the past six years. Since many health care programs, such as TRICARE, Medicaid, and private insurers link their payments to Medicare rates, cuts in other systems will compound the impact of the projected Medicare cuts.

Physicians should be reimbursed in a more predictable and equitable manner, similar to other Medicare providers. Physicians are the only Medicare providers subjected to the flawed SGR formula. Since the SGR is tied to flawed methodologies, it routinely produces negative updates based upon economic factors, not the health care needs of beneficiaries. Additionally, the formula has never demonstrated the ability to reflect increases in physicians' costs of providing care. Every Medicare provider, except physicians, receives annual positive updates based upon increases in practice costs. Hospitals and other Medicare providers do not face the possibility of "real dollar" cuts—only adjustments in their rates of increase.

It is important to recognize that, in 2007, substantial changes to other components of the Medicare payment formula will shift billions of dollars which will lead to cuts of up to 10 percent to 12 percent for certain physician services. Congress must act to stabilize the update to the conversion factor in order to bring stability to this volatile system and dampen the impact of payment cuts caused by unrelated policy changes. The non-SGR related changes to physician payment in 2007 include:

Geographic Practice Cost Index (GPCI)

The Medicare Prescription Drug, Modernization and Improvement Act (MMA) (P.L. 108-173) included a three-year floor of 1.0 on all work GPCI adjustments. This provision is set

to expire on December 31, 2006. Nationwide, 58 of the 89 physician payment areas have benefited from this provision. If this provision is not extended, many physicians, especially those in rural areas, will experience additional cuts. The AOA supports the "Medicare Rural Health Providers Payment Extension Act." (H.R. 5118) introduced by Rep. Greg Walden. We urge the Committee to include the provisions of H.R. 5118 in any legislative package considered this year.

Five-Year Review

Every five years, CMS is required by law to review all work relative value units (RVU) and make needed adjustments. These adjustments must be made in a budget neutral manner. Changes related to the third five-year review will be implemented on January 1, 2007.

In total, more than $4 billion will be shifted to E&M codes, which will be increased by upwards of 35 percent in some instances. The AOA supports the changes in values for E&M codes. We believe E&M codes have been undervalued historically. The proposed changes are fair and should be implemented. We do recognize that increases in E&M codes likely will require decreases in other codes as a means to meet statutory budget neutrality requirements. The AOA continues to urge CMS to apply required budget neutrality to the conversion factor versus work RVUs as proposed by the Agency.

Practice Expense

CMS also has announced significant changes to the formulas used to determine the practice expense RVU. These changes also are budget neutral and will shift approximately $4 billion. Again, these increases will require cuts in other areas of the physician fee schedule.

This dramatic shift in the allocation of funding will have a significant impact on many physicians across the country. The AOA is concerned about the impact a reduction in the SGR, along with cuts resulting in the reallocation of funding required by other policy changes, might have upon physicians. While the total impact of the changes will vary by specialty, geographic location, and practice composition; it is clear that physicians in certain specialties may see significant cuts prior to any adjustments to the conversion factor made as a result of the SGR formula. For these reasons,

we call upon Congress to ensure that all physicians participating in the Medicare program receive a positive payment update in 2007.

Problems with the Sustainable Growth Rate (SGR) Formula

Concerned that the 1992 fee schedule failed to control Medicare spending, five years later Congress again examined physician payments. The "Balanced Budget Act of 1997" (BBA 97) (P.L. 105-33) established a new mechanism, the sustainable growth rate, to cap payments when utilization increases relative to the growth of gross domestic product (Congressional Budget Office, "Impact of the BBA," June 10, 1999).

This explanation of the SGR not only highlights the objectives of the formula, but also demonstrates the serious flaws that resulted. The AOA would like to focus on three central problems associated with the current formula—physician administered drugs, the addition of new benefits and coverage decisions, and the economic volatility of the formula.

Utilization of Physician Services—The SGR penalizes physicians with lower payments when utilization exceeds the SGR spending target. However, utilization is often beyond the control of the individual physician or physicians as a whole.

Over the past twenty years, public and private payers successfully moved the delivery of health care away from the hospital into physicians' offices. They did so through a shift in payment policies, coverage decisions, and a trend away from acute based care to a more ambulatory based delivery system. This movement continues today. As a result, fewer patients receive care in an inpatient hospital setting. Instead, they rely upon their physicians for more health care services, leading to greater utilization of physician services.

For the past several years, CMS has failed to account for the many policy changes and coverage decisions in the SGR spending targets. With numerous new beneficiary services included in the "Medicare Modernization Act" (MMA) (P.L. 108-173) and an expected growth in the number of national coverage decisions, utilization is certain to increase over the next decade. The Congressional Budget Office (CBO) cites legislative and administrative program expansions as major contributors to the recent increases in Medicare utilization.

The other major contributors were increased enrollment and advances in medical technology.

Physician Administered Drugs—An additional major contributor to increased utilization of physician services is the inclusion of the costs of physician-administered drugs in the SGR. Because of the rapidly increasing costs of these drugs, their inclusion greatly affects the amount of actual expenditures and reduces payments for physician services.

Over the past few years, you and the Committee encouraged the Administration to remove the cost of physician-administered drugs from the formula. The AOA encourages the Committee to continue pressing the Administration on this issue. We do not believe the definition of physician services included in Section 1848 of Title XVIII includes prescription drugs or biological products. Removal of these costs would ease the economic constraints that face Congress and make reform of the physician payment formula more feasible.

Gross Domestic Product—The use of the GDP as a factor in the physician payment formula subjects physicians to the fluctuating national economy. We recognize the important provisions included in the MMA that altered the use of the GDP to a 10-year rolling average versus an annual factor. Again, we appreciate your leadership and insistence that that provision be included in the final legislation.

However, we continue to be concerned that a downturn in the economy will have an adverse impact on the formula. We argue that the health care needs of beneficiaries do not change based upon the economic environment. Physician reimbursements should be based upon the costs of providing health care services to seniors and the disabled, not the ups and downs of the economy.

BENEFICIARY ACCESS TO CARE

The continued use of the flawed and unstable sustainable growth rate methodology may result in a loss of physician services for millions of Medicare beneficiaries. Osteopathic physicians from across

the country have told the AOA that future cuts will hamper their ability to continue providing services to Medicare beneficiaries.

The AOA surveyed its members on July 14-16, 2006 to analyze their reactions to previous and future payment policies. The AOA asked what actions they or their practice would take if the projected cuts in Medicare physician payments were implemented. The results are concerning. Twenty-one percent said they would stop providing services to Medicare beneficiaries. Twenty-six percent said they would stop accepting new Medicare beneficiaries in their practice and thirty-eight percent said they would limit the number of Medicare beneficiaries accepted in their practice.

Many experts concur with these findings. According to a 2005 survey conducted by MedPAC, 25 percent of Medicare beneficiaries reported that they had some problem finding a primary care physician. MedPAC concluded that Medicare beneficiaries *"may be experiencing more difficulty accessing primary care physicians in recent years and to a greater degree than privately insured individuals."*

While there are some steps that can be taken by physicians to streamline their business operations, they simply cannot afford to have the gap between costs and reimbursements continue to grow at the current dramatic rate. Many osteopathic physicians practice in solo or small group settings. These small businesses have a difficult time absorbing losses. Eventually, the deficit between costs and reimbursements will be too great and physicians will be forced to limit, if not eliminate, services to Medicare beneficiaries.

Additionally, continued cuts limit the ability of physicians to adopt new technologies, such as electronic health records, into their practices.

HEALTH INFORMATION TECHNOLOGY

A viable interoperable health information system is key to the implementation and success of quality-improvement and performance-based payment methodologies. For these reasons, we support the "Health Information Technology Promotion Act" (H.R. 4157).

Our main focus is ensuring that software and hardware used throughout the healthcare system are interoperable. There is no benefit to be found in the utilization of systems unable to communicate with others. Additionally, the AOA believes strongly that systems developed and implemented must not compromise the essential patient-physician relationship. Medical decisions must remain in the hands of physicians and their patients, independent of third-party intrusion.

The AOA remains concerned about the costs of health information systems for individual physicians, especially those in rural communities. According to a 2005 study published in *Health Affairs*, the average costs of implementing electronic health records was $44,000 per full-time equivalent provider, with ongoing costs of $8,500 per provider per year for maintenance of the system. This is not an insignificant investment. With physicians already facing deep reductions in reimbursements, without financial assistance, many physicians will be prohibited from adopting and implementing new technologies.

A July 2006 survey conducted by the AOA demonstrates this concern. According to the survey, 90 percent of osteopathic physicians responding agreed that "decreased reimbursements will hinder their ability to purchase and implement new health information technologies in their practice." While we continue to advocate for financial assistance for these physicians, we appreciate inclusion of provisions in H.R. 4157 that provide safe harbors allowing hospitals and other health care entities to provide health information hardware, software, and training to physicians. This would, in our opinion, facilitate rapid development of health information systems in many communities.

SUMMARY

Reform of the Medicare physician payment formula, specifically, the repeal of the sustainable growth rate (SGR) formula, is a top legislative priority for the AOA. The SGR formula is unpredictable, inequitable, and fails to account accurately for physician practice costs. We will continue to advocate for the establishment of a more equitable and predictable payment formula that reflects the annual increases in physicians practice costs.

The AOA believes that a multi-faceted approach is needed to address this issue. We support provisions included in the Barton discussion draft, H.R. 5866, and H.R. 5916. Each of these bills

offer valuable ideas that can contribute to the Committees efforts. We have factored many of the concepts included in those bills into the following recommendations offered as a framework for the Committees actions:

1. Congress must act to ensure that all physicians participating in the Medicare program receive a positive update in 2007. We continue to support the MedPAC recommendation that all physicians receive a 2.8 percent increase in 2007, but we recognize that this may be unobtainable. However, we believe that the update for 2007 should be "significant" given the fact that physician payments are well below inflation over the past five years. If the 2007 cut is realized, physician payments under Medicare will fall 20 percent or more below inflation over the past six years. The steady decline in reimbursements and the impact upon physicians and beneficiaries are well documented in our testimony and other reports.

2. Congress should consider extending the 2007 positive payment update for two to three years. By ensuring positive payment updates, Congress would restore some stability in the physician payment formula and provide all physicians some degree of confidence in what the future of the Medicare program may hold with respect to reimbursement. Additionally, multiple years of positive payment updates would provide Congress time to focus on long-term solutions and the development of a new Medicare physician payment methodology.

3. Quality-reporting programs should be voluntary and "phased-in" over a two to three year period.

4. Quality-reporting programs should provide maximum opportunity for participation. The AOA encourages the "menu" approach versus a program that requires all physicians to report on a standard set of measures. This menu of options should include quality measures, structural measures, patient safety measures, and allow physicians to participate in existing data collection and evaluation programs operated by public and private entities.

5. The development of quality measures must originate with physicians. The AOA does not support any program that would allow CMS or other payers to develop and implement quality measures without the direct involvement of physicians. We strongly promote the

Physician Consortium for Performance Improvement as the most appropriate body for the development of physician quality measures.

6. Resource management programs should be confidential and aimed at educating individual physicians. The AOA is concerned that resource management programs, if not properly administered, could serve as a means of intimidating physicians into reducing the types of services they offer their patients based upon financial not medical guidelines. We agree that physicians should be stewards of the Medicare program and work to ensure that beneficiaries receive optimal care based upon their medical condition with an eye on the efficient delivery of such care. However, we do not believe that physicians should be hesitant to provide needed services due to undue scrutiny aimed at their use of medical resources.

7. Congress should develop a new physician payment methodology that provides annual increases equal to increases in practice costs. Physicians participating in quality improvement programs should be provided additional compensation. The basis for a future payment formula should be aligned closely to actual Medicare spending on physician services and move away from the faulty data currently used in the SGR formula. The new formula should be flexible and capable of capturing changes due to growth in beneficiaries and changes in medical sciences.

8. Congress should evaluate Medicare financing as a whole, versus the individual parts. The AOA urges Congress to evaluate the overall financing structure of the Medicare program to determine if increases in Part B as a result of improved access and quality of care delivered results in savings in other parts of the program. We view the elimination of "Medicare funding silos" as a reasonable and obtainable means of financing, partially, a future physician payment formula.

I appreciate the opportunity to testify before the Committee on Energy and Commerce Subcommittee on Health. Again, I applaud your continued efforts to assist physicians and their patients.

The AOA and our members stand ready to work with you to develop a payment methodology that secures patient access, improves the quality of care provided, and appropriately reimburses physicians for their services. Additionally, we stand ready to assist in the development of new programs that improve quality, streamline the practice of medicine, and make the delivery of health care more efficient and affordable.